December 2012 MH/DS Redesign Workgroups and Committee- Summary of Recommendations

A. **Children's Disability Services Workgroup**

1. In order to fully plan and execute a comprehensive and inclusive mental health and disability system for children and youth, enact legislation creating a state level Iowa Children's Cabinet, led by DHS, to promote optimal, holistic well-being to all children in the state. The recommendation includes the responsibilities of the cabinet, the governance structure, membership, and leadership.

B. Judicial Branch and DHS Workgroup.

1. Modify the application for involuntary commitment so that it is the same for Iowa Code chapter 125 (substance-related disorders) and Iowa Code chapter 229 (hospitalization of persons with mental illness).
2. Require the offer of a precommitment screen before the filing of an application for involuntary commitment for a substance-related disorder or mental illness.
3. Sunset the Iowa Code provisions relating to the involuntary commitment process under Iowa Code chapter 222 for persons with an intellectual disability. The use of the process is infrequent since the need is filled primarily through guardianships.
4. Modify the language in Iowa Code chapters 125 and 229, relating to involuntary commitment to reflect community-based services language. Current language references an institutional system.
5. Shift responsibility for the statewide Mental Health Advocates Program to become a unit attached to the Department of Inspections and Appeals (DIA).
6. Consider assignment of advocates for persons committed for substance-related disorders after the DIA unit is in place.
7. Consider assignment of advocates for persons who have been found not guilty of a crime by reason of insanity after the DIA unit is in place.
8. Ensure that adequate funding for the workgroup recommendations is provided.
9. Implement a system for identifying available beds in the state for involuntary commitment.
10. Provide for regional core services to include justice-involved services of mental health courts with diversion and conditions of sentencing models and a jail diversion program.
11. Ensure there is a qualified professional workforce as necessary to provide needed services to persons with mental health and substance-related disorders, both in rural and urban areas of the state.
12. Adopt various recommendations of the Judicial Advocates for Persons with Mental Illness (JAMI), including appointment of advocates based on residence, physician reporting forms, authorization for advocates to attend hearings, and for preferred qualifications of advocates.

C. Outcomes and Performance Measures Committee

1. DHS should develop an Internet-based dashboard report to demonstrate the performance and effectiveness of Iowa's system.
2. Outcomes and performance measures should fall within six domains: Access to Services, Life in the Community, Person-centeredness, Health and Wellness, Quality of Life and Safety, and Family and Natural Supports.
3. DHS should use a survey process to collect and evaluate information directly from individuals and families receiving services and from the providers delivering these services.
4. DHS should convene a group of experts in survey development and outcomes and performance measurement to design the survey and assist in piloting the tool. The survey should be tested for validity and reliability, and stakeholders should have the opportunity to review the instrument as it is developed.
5. DHS should develop a budget that identifies the costs of implementing the outcomes and performance measurement system.
6. Only data that will be used should be collected, and DHS should convene a team to identify what information will no longer be collected.
7. Outcomes and performance measures should be reflective of the disability populations identified in SF 2315 and address all co-occurring disabilities.
8. Future decisions should be based on the information collected from the outcomes and performance measures system.
9. Outcomes and performance measures should be evaluated across both Medicaid and non-Medicaid systems.
10. Surveys should be conflict-free, meaning individuals and their family members will not be placed in a position to answer questions about outcomes and quality of services from those who directly provide services.

D. Service System Data and Statistical Information

1. Entities within the MH/DS system will not be required to use the same operational/transactional system.
2. Operational/transactional systems need to have the capability to exchange information. Information that is exchanged needs to be labeled consistently and have the same definition.
3. The central data warehouse should have the capability to match an individual's information from different sources using a unique individual identifier.
4. Privacy and security needs to be maintained consistent with defined roles and responsibilities.

5. DHS should house and manage the data warehouse and be given guidance from key stakeholders.
6. Efforts should be made to integrate the central data warehouse with other electronic data information exchange systems being implemented statewide.
7. An organized, coordinated effort among all MH/DS stakeholders should be in place to minimize the cost of operational/transactional systems now and in the future.

E. Transition Committee

1. Develop and approve a Transition Fund allocation method that uses the entire available CHIP contingency fund for the transition and unintended consequences related to redesign of Iowa's mental health delivery system passed by the 2012 Legislature.
2. Provide that no child or adult consumer loses services as a result of the transition.
3. Establish $47.28 per capita as the guidance for counties in determining their budget for MH-DS services and provide for the equalization funding as soon as possible.
4. Award equalization funding up to the $47.28 level to regions as opposed to individual counties.
5. The Mental Health and Disability Services Redesign Fiscal Viability Study Committee should establish an appeals process for counties requesting an exemption from joining a region if the Chapter 17A appeals process is deemed not effective.
6. Set aside the statutory requirement for counties to submit a strategic plan for state fiscal year 2013-2014 as counties move to regionalization. The current county management plan will stay in place.
7. The Mental Health and Disability Services Redesign Fiscal Viability Study Committee should begin to look at systemic barriers to implementing co-occurring and multi-occurring service development and coordination strategies.
8. Set June 30, 2013, as the end date for identifying county obligations for Medicaid bills. After that date, the state would receive any credits and pay any obligations resulting from retroactive cost adjustments, etc. This would allow counties to move forward with budgeting.
9. Authorize DHS to allocate to counties (regions) for state fiscal year 2013-2014 the money that is used for the current state payment program for services for individuals who are 100 percent county funded.
10. Authorize individuals in the community corrections system to have access to regional MH/DS services and provide for funding to pay for the access to these services.